

Floor Amendment to SB 173-FN

1 Amend the bill by replacing all after the enacting clause with the following:

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3 1 New Chapter; Prohibition on Balance Billing Covered Persons for Health Care Services.

4 Amend RSA by inserting after chapter 358-S the following new chapter:

5

CHAPTER 358-T

6

PROHIBITION ON BALANCE BILLING COVERED PERSONS FOR HEALTH CARE SERVICES

7

358-T:1 Definitions. In this chapter:

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I. "Covered benefits" means "covered benefits" as defined in RSA 420-J:3.

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II. "Covered person" means "covered person" as defined in RSA 420-J:3.

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III. "Emergency medical condition" means "emergency medical condition" as defined in RSA

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420-J:3.

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IV. "Emergency services" means "emergency services" as defined in RSA 420-J:3.

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V. "Facility" means "facility" as defined in RSA 420-J:3.

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VI. "Health benefit plan" means a policy, contract certificate or agreement entered into,

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offered or issued by a health carrier or group health plan, as defined in 42 U.S.C. section 300gg-

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91(a), to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

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VII. "Health care provider" or "provider" means "health care provider" or "provider" as

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defined in RSA 420-J:3.

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VIII. "Health carrier" means "health carrier" as defined in RSA 420-J:3.

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IX. "Nonparticipating emergency facility" means "nonparticipating emergency facility" as

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defined in RSA 420-J:3.

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X. "Nonparticipating provider" means "nonparticipating provider" as defined in RSA 420-

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J:3.

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XI. "Participating provider or facility" means "participating provider or facility" as defined in

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RSA 420-J:3.

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358-T:2 Balance Billing in Cases of Emergency Services. If a covered person with benefits

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covering emergency services under a health benefit plan is furnished emergency services, then:

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I. In the case that the hospital emergency department or independent freestanding

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emergency department is a nonparticipating emergency facility, the hospital emergency department

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or independent freestanding emergency department shall not bill, and shall not hold liable, the

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covered person for a payment amount for such emergency services that is more than the cost-sharing

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requirement for such services under the covered person's health benefit plan; and

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1 II. In the case that such emergency services are furnished by a nonparticipating provider,
2 the health care provider shall not bill, and shall not hold liable, such covered person for a payment
3 amount for such emergency services that is more than the cost-sharing requirement for such services
4 under the covered person's health benefit plan.

5 358-T:3 Balance Billing in Cases of Non-emergency Services Performed by Nonparticipating
6 Providers at Certain Participating Health Care Facilities.

7 I. Subject to paragraph II, if a covered person is furnished health care items or services,
8 other than emergency services, by a nonparticipating provider at a participating facility for which
9 benefits are provided under the covered person's health benefit plan, then such provider shall not
10 bill, and shall not hold liable, such covered person for a payment amount for such item or service
11 furnished by such provider with respect to a visit at such facility that is more than the cost-sharing
12 requirement for such item or service under the covered person's health benefit plan.

13 II. Paragraph I shall not apply with respect to items or services, other than items or services
14 that qualify as ancillary services under 42 U.S.C. section 300gg-132 (b)(2) and (3), furnished by a
15 nonparticipating provider to a covered person if the provider satisfies the notice and consent criteria
16 under 42 U.S.C. section 300gg-132 (c) and (d).

17 358-T:4 Dispute Resolution Regarding the Fair Value of Health Care Items or Services. In the
18 event of a dispute between a nonparticipating provider or nonparticipating emergency facility and a
19 health carrier relative to the fair value of emergency health care items or services with respect to
20 which balance billing is prohibited under RSA 358-T:2 or in the event of a dispute between a
21 nonparticipating provider and a health carrier relative to the fair value of health care items or
22 services with respect to which balance billing is prohibited under RSA 358-T:3, the insurance
23 commissioner shall make available, as provided in RSA 420-J:8-e, an independent dispute resolution
24 process to determine the fair value payment amount.

25 2 New Paragraph; Consumer Protection Act; Acts Unlawful; Balance Billing. Amend RSA 358-
26 A:2 by inserting after paragraph XVIII the following new paragraph:

27 XIX. Balance billing a covered person in violation of RSA 358-T.

28 3 Managed Care Law; Definitions. RSA 420-J:3, XV and XVI are repealed and reenacted to read
29 as follows:

30 XV. "Emergency medical condition" means "emergency medical condition" as defined in 42
31 U.S.C. section 300gg-111(a)(3)(B).

32 XVI. "Emergency services" means health care services, including mental health and
33 substance use disorder treatment services, that meet the definition of "emergency services" in 42
34 U.S.C. section 300gg-111(a)(3)(C).

35 4 New Paragraph; Managed Care Law. RSA 420-J:3 by inserting after paragraph XVI the
36 following new paragraph:

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1 XVI-a. "Episode of care" means the period of time during which all of the health care
2 services that are needed to care for a patient's clinical condition or to complete a procedure are
3 delivered.

4 5 New Paragraphs; Managed Care Law; Definitions. Amend RSA 420-J:3 by inserting after
5 paragraph XXVI the following new paragraphs:

6 XXVI-a. "Nonparticipating emergency facility" means an emergency department of a
7 hospital or an independent freestanding emergency department as defined in 42 U.S.C. section
8 300gg-111(a)(3)(D) that does not have a contractual relationship directly or indirectly with a health
9 carrier.

10 XXVI-b. "Nonparticipating provider" means any health care provider, excluding ground and
11 air ambulance service providers, who is acting within the scope of practice of that provider's license
12 or certification under applicable state law and who does not have a contractual relationship directly
13 or indirectly with a health carrier.

14 6 Managed Care Law; Definition of Participating Provider or Facility. Amend RSA 420-J:3,
15 XXVII to read as follows:

16 XXVII. "Participating provider *or facility*" means a provider [~~who~~] *or facility that*, under
17 a contract with the health carrier or with its contractor or subcontractor, has agreed to provide
18 health care services to covered persons with an expectation of receiving payment, other than
19 coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

20 7 New Paragraph; Managed Care Law; Definitions; Qualifying Payment Amount. Amend RSA
21 420-J:3 by inserting after paragraph XXIX the following new paragraph:

22 XXIX-a. "Qualifying payment amount" means "qualifying payment amount" as defined in 42
23 U.S.C. section 300gg-111(3)(E).

24 8 Coverage for Emergency Services; Definitions. RSA 417-F:1 is repealed and reenacted to read
25 as follows:

26 417-F:1 Definitions. In this chapter:

27 I. "Emergency medical condition" means "emergency medical condition" as defined in RSA
28 420-J:3, XV.

29 II. "Emergency services" means "emergency services" as defined in RSA 420-J:3, XVI.

30 III. "Insurer" means any entity providing managed care coverage or accident or health
31 insurance or accident and health insurance policies, contracts, certificates, or other evidence of
32 coverage to enrollees, insureds, or subscribers pursuant to RSA 415, 415-A, 420-A, 420-B, or 420-J.

33 9 Managed Care Law; Determining the Fair Value of Certain Health Care Items or Services
34 Provided by Nonparticipating Providers. RSA 420-J:8-e is repealed and reenacted to read as follows:

35 420-J:8-e Determining the Fair Value of Certain Health Care Items or Services Provided by
36 Nonparticipating Providers. Nonparticipating providers or emergency facilities and health carriers

1 shall have access to a state-based independent dispute resolution (IDR) process for determining the
2 fair value of certain health care items or services as follows:

3 I. Determination through open negotiation.

4 (a) With respect to an item or service furnished by a nonparticipating provider or
5 nonparticipating emergency facility to which the prohibition on balance billing in RSA 358-T applies
6 and for which a payment is required to be made by the health carrier under RSA 420-J:8-g or under
7 RSA 420-J:8-h, the provider, facility or health carrier may, during the 30-day period beginning on
8 the day the provider or facility receives an initial payment or a notice of denial of payment from the
9 health carrier regarding a claim for payment for such item or service, initiate open negotiations
10 under this paragraph between such provider or facility and health carrier for purposes of
11 determining, during the open negotiation period, a fair value amount agreed on by the parties for
12 payment, including any cost-sharing, for such item or service. For purposes of this paragraph, the
13 state-based open negotiation period relating to an item or service is the 20-day period beginning on
14 the date of initiation of the negotiations with respect to such item or service.

15 (b) Each health carrier shall provide to the commissioner a designated point of contact,
16 including his or her email address, for open negotiations, and the commissioner shall publish and
17 update a directory of such designated point of contacts. A provider or facility properly initiates open
18 negotiations by emailing such designated point of contact and providing information sufficient to
19 identify the initial payment or notice of denial of payment at issue.

20 II. Accessing the state-based IDR process in case of failed negotiations. If open negotiations
21 with respect to an item or service under paragraph I do not result in a determination of an amount of
22 payment for such item or service by the last day of the state-based open negotiation period, the
23 provider or facility may initiate the state-based IDR process by delivering, simultaneously to the
24 commissioner and to the health carrier during the 4-day period beginning on the day after the open
25 negotiation period, a review request notification form containing such information as specified by the
26 commissioner. The date of submission of the review request notification form shall be the date of
27 receipt of a qualifying form by the commissioner.

28 III. Submission of offers. Not less than 10 days after the date of submission of the review
29 request notification, the provider or facility and health carrier party to such IDR process regarding
30 the fair value of an item or service shall each submit to the IDR entity appointed pursuant to this
31 section:

32 (a) An offer for a payment amount for such item or service furnished by such provider or
33 facility;

34 (b) Such information as is requested by the independent review entity relating to such
35 offer; and

36 (c) Any information relating to the offer deemed by the provider, facility, or health
37 carrier to be relevant to the fair value determination.

1 IV. Authority to continue negotiations. Under the state IDR process provided for in this
2 section, in the case that the disputing parties agree on a payment amount for the item or service in
3 dispute during the period in which the dispute is under review by the selected IDR entity and before
4 the date on which the selected IDR entity makes its fair value determination, then such agreed
5 amount shall qualify as the fair value amount without the necessity of a fair value determination by
6 the IDR entity. This agreement during the period in which the dispute is before the IDR entity shall
7 not affect the fee that the IDR entity is entitled to collect.

8 V. Considerations in the fair value determination.

9 (a) In general, in determining which offer is the payment amount to be applied pursuant
10 to this section as the fair value of items or services rendered, the IDR entity shall consider:

11 (1) The qualifying payment amount for the item or service furnished; and

12 (2) Subject to subparagraph (c), information regarding any circumstance described in
13 subparagraph (b), such information as is requested and received by the IDR entity, and any
14 additional relevant information provided by the parties.

15 (b) In addition to the considerations listed in RSA 420-J:8-e, V(a), the IDR entity shall
16 consider, if such information is provided by either of the parties:

17 (1) The level of training, experience, and quality and outcomes measurements of the
18 provider or facility that furnished such item or service, such as those endorsed by the consensus-
19 based entity authorized in 42 U.S.C. section 1395aaa.

20 (2) The market share held by the nonparticipating provider or facility or that of the
21 plan or issuer in the geographic region in which the item or service was provided.

22 (3) The acuity of the individual receiving such item or service or the complexity of
23 furnishing such item or service to such individual.

24 (4) The teaching status, case mix, and scope of services of the nonparticipating
25 facility that furnished such item or service.

26 (5) Demonstrations of good faith efforts, or lack of good faith efforts, made by the
27 nonparticipating provider or nonparticipating facility or the health carrier to enter into network
28 agreements and, if applicable, contracted rates between the provider or facility, as applicable, and
29 the health carrier, as applicable, during the previous 4 plan years.

30 (c) In determining which offer is the payment to be applied pursuant to this sub-section
31 as the fair value of items or services rendered, the IDR entity shall not consider usual and customary
32 charges, the amount that would have been billed by such provider or facility with respect to such
33 items and services had the provisions of 42 U.S.C. section 300gg– 131 or 300gg–132, as applicable,
34 not applied, or the payment or reimbursement rate for such items and services furnished by such
35 provider or facility payable by a public payor, including under the Medicare program under 42
36 U.S.C. 1395 et seq., under the Medicaid program under 42

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1 U.S.C. 1396 et seq., under the Children's Health Insurance Program under 42 U.S.C. 1397aa et seq.,
2 and under the federal TRICARE program.

3 VI. Batching of items and services.

4 (a) The provider or facility initiating the IDR process described in this section may batch
5 items and services from more than one episode of care for consideration jointly as part of a single
6 determination by a single independent dispute resolution entity provided that the following
7 requirements are met:

8 (1) Such items and services to be included in such determination are furnished by
9 the same provider or facility;

10 (2) Payment for such items and services is required to be made by the same health
11 carrier;

12 (3) Such items and services are related to the treatment of a similar condition; and

13 (4) Such items and services were furnished during the 30-day period following the
14 date on which the first item or service included with respect to such determination was furnished or
15 an alternative period as determined by the commissioner, for use in limited situations, such as by
16 the consent of the parties or in the case of low-volume items and services, to encourage procedural
17 efficiency and minimize health carrier and provider administrative costs.

18 (b) In carrying out subparagraph (a), the commissioner shall provide that, in the case of
19 items and services which are included by a provider or facility as part of a single episode of care, the
20 items and services furnished in that single episode of care may be part of a single fair value
21 determination under this section.

22 VII. Fair value determination based on written record. In making the fair value
23 determination, the IDR entity shall consider only such written material as is submitted by the
24 parties and shall not engage in ex parte contact with either party.

25 VIII. Timing of the fair value determination. Not later than 30 days after the submission of
26 offers under paragraph III with respect to a fair value determination for an item or service, the IDR
27 entity shall:

28 (a) Taking into account the considerations specified in paragraph V, select one of the
29 offers submitted under paragraph III to be the amount of payment for such item or service
30 determined under this section; and

31 (b) Provide written notification to the provider or facility and the health carrier party to
32 such determination of the offer selected under subparagraph (a).

33 IX. Effects of determination. The fair value decision of the IDR entity shall be binding on
34 the parties and shall not be subject to re-review except in the case of fraud. The decision shall be
35 enforceable against the health carrier by the commissioner pursuant to the penalty provisions of
36 RSA 420-J:14 and under the enforcement provisions of RSA 417. The fair value dispute resolution
37 process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and

1 the decision of the independent dispute resolution entity shall not be subject to rehearing and appeal
2 pursuant to RSA 541 or RSA 400-A:17.

3 X. Timing of payment of fair value amount.

4 (a) The health carrier shall make payment to the nonparticipating provider or facility
5 within 30 days after the date on which:

6 (1) A fair value amount is agreed on by the parties in open negotiations under
7 paragraph I or while the dispute is before the IDR entity as provided in paragraph IV; or

8 (2) A fair value determination is made by the IDR entity under paragraph VIII.

9 (b) If the fair value amount is not paid in full within the 30-day period under
10 subparagraph (a), the health carrier shall also be liable to the nonparticipating provider or facility
11 for an interest payment of 5 percent per month, in addition to all other remedies otherwise provided
12 by law. In addition, the nonparticipating provider or facility may recover from the health carrier,
13 upon a judicial finding that the out-of-network rate was not timely paid, reasonable attorney's fees
14 for advising and representing the nonparticipating provider or facility in an action against a carrier
15 for prompt payment of the fair value amount.

16 XI. Certification and selection of independent dispute resolution entities.

17 (a) The commissioner shall certify independent dispute resolution entities that:

18 (1) Make application to the commissioner for certification on a form requiring such
19 information as specified by the commissioner through an insurance department bulletin; and

20 (2) Demonstrate that they are certified as IDR entities under the federal process set
21 out in 42 U.S.C. section 300gg-111(c)(4) or otherwise meet these federal standards for certification;
22 and

23 (3) Satisfy such additional requirements established by the commissioner.

24 (b) The commissioner shall utilize the process set out in 42 U.S.C. section 300gg-
25 111(c)(4)(F) for the selection of an independent dispute resolution entity to adjudicate fair value
26 disputes under this section.

27 XII. Costs of the independent dispute resolution process.

28 (a) There shall be no administrative fee charged by the commissioner for administering
29 the independent dispute resolution process.

30 (b) The commissioner shall establish by rulemaking a fee schedule, which may vary by
31 complexity of the matter in dispute, that independent dispute resolution entities may charge for the
32 review and resolution of disputes with respect to the fair value of unbatched and batched services.
33 To the extent practicable, the fee schedule shall be sufficient to ensure that an adequate number of
34 entities are certified as required for the timely and efficient adjudication of fair value disputes and
35 sufficiently limited to produce a cost-effective option for disputing parties to reach a fair value
36 amount.

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1 (c) Each party participating in a fair value dispute resolution process under this section
2 shall submit, together with or no later than 10 days after its submission of an offer for a payment
3 amount as provided under paragraph III, one half of the fee charged by the certified IDR entity. If
4 any party does not timely submit its half of the IDR entity's fee together with its offer for a payment
5 amount, then the IDR entity shall, without further consideration, select the offer of the party that
6 has paid its half of the fee as the winning offer and notify the parties of the determination as
7 provided in paragraph VIII.

8 XIII. The commissioner shall make the IDR process set out in this section available, on a
9 case-by-case basis, to providers or facilities that are party to a fair value dispute about items or
10 services to which the prohibition on balance billing in RSA 358-T applies. This option shall include
11 fair value disputes in which one of the parties is a self-funded health plan not otherwise subject to
12 regulation under this chapter only if the self-funded plan has opted into the state IDR program
13 generally, with respect to all subsequent fair value disputes, and consented to be bound by the terms
14 of the process as set out in this section through the submission to the commissioner of a program
15 opt-in form which shall be made available by the commissioner.

16 XIV. The authority of the commissioner to administer the IDR process set out in this section
17 shall arise on a case-by-case basis with respect to specific items or services as providers or facilities
18 choose to invoke the state IDR process to determine the fair value of that item or service. This
19 section shall constitute a "specified state law" under 42 U.S.C. section 300gg-111 (a)(3)(I)
20 contextually with respect to an item or service and only when a provider or facility has invoked the
21 state IDR process with respect to that item or service. This section is not intended to preempt or
22 displace the authority or obligation of the secretary of the federal department of health and human
23 services to administer the federal IDR process as provided under 42 U.S.C. section 300gg-111
24 whenever the provider or facility to which the prohibition on balance billing in RSA 358-T applies
25 does not choose to invoke the state IDR process.

26 XV. If a provider or facility that is party to a fair value dispute about items or services to
27 which the prohibition on balance billing in RSA 358-T applies invokes the state IDR process set out
28 in this chapter by submission of a review request notification under paragraph II, then both parties
29 shall be precluded from accessing the federal IDR process under 42 U.S.C. section 300gg-111. If no
30 party to a fair value dispute about items or services to which the prohibition on balance billing in
31 RSA 358-T applies invokes the state IDR process set out in this chapter by submitting a review
32 request notification under paragraph II within the 4-day period following the 20 day state-based
33 open negotiation period, then the federal IDR process under 42 U.S.C. section 300gg-111 shall be
34 available to both parties after the expiration of the federal 30-day open negotiation period as
35 provided in 42 U.S.C. section 300gg-111(c)(1)(B).

36 XVI. If a party to a fair value dispute about items or services to which the prohibition on
37 balance billing in RSA 358-T applies initiates the state IDR process set out in this chapter by

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1 submission of a review request notification under paragraph II, then the disputing parties shall be
2 limited to the state IDR process for determining the fair value of all other items and services that
3 are part of the same episode of care, and both parties shall be precluded from accessing the federal
4 IDR process under 42 U.S.C. section 300gg-111 with respect to all such items or services.

5 XVII. The commissioner shall enter into a collaborative enforcement agreement with the
6 Centers for Medicare and Medicaid Services (CMS) in order to set up processes and systems in
7 coordination with CMS to resolve potential federal IDR eligibility questions arising from the case-
8 specific applicability of the specified state law created in this chapter.

9 10 New Sections; Managed Care Law; Coverage and Payment for Emergency Services Provided
10 by Nonparticipating Providers or Nonparticipating Emergency Facilities and for Services Provided
11 at Participating Facilities by Nonparticipating Providers. Amend RSA 420-J by inserting after
12 section 8-f the following new sections:

13 420-J:8-g Coverage and Payment for Emergency Services Provided by Nonparticipating
14 Providers or Nonparticipating Emergency Facilities.

15 I. Each insurer that issues or renews any policy of health insurance providing benefits for
16 emergency services shall cover emergency services provided by a nonparticipating provider or
17 nonparticipating emergency facility in the same manner and without imposing any additional
18 requirements as if the services were provided by a participating provider or participating emergency
19 facility.

20 II. The patient's cost-sharing for items or emergency services provided by a nonparticipating
21 provider or nonparticipating emergency facility shall be calculated by the health carrier based on the
22 qualifying payment amount.

23 III. The insurer shall pay the nonparticipating provider of emergency services or
24 nonparticipating emergency facility an amount based on the fair value considerations set out in RSA
25 420-J:8-e, IV, less any cost-sharing for the services provided.

26 IV. In the event of a dispute between a nonparticipating provider or facility and an insurer
27 relative to the fair value of an item or service under this section, the commissioner shall make
28 available, as provided in RSA 420-J:8-e, an independent dispute resolution process to determine the
29 fair value payment amount.

30 420-J:8-h Coverage and Payment for Services Provided at Participating Facilities by
31 Nonparticipating Providers.

32 I. Each health carrier that issues or renews any policy of health insurance shall cover
33 services provided by nonparticipating providers at a participating facility in the same manner and
34 without imposing any additional requirements as if the services were provided by a participating
35 provider.

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1 II. The patient's cost-sharing for items or services provided by a nonparticipating provider at
2 a participating facility shall be calculated using the qualified payment amount for the item or
3 service.

4 III. The health carrier shall pay the nonparticipating provider an amount based on the fair
5 value considerations set out in RSA 420-J:8-e, IV, less any cost-sharing for the services provided.

6 IV. In the event of a dispute between a nonparticipating provider and a health carrier
7 relative to the fair value of an item or service under this section, the commissioner shall make
8 available, as provided in RSA 420-J:8-e, an independent dispute resolution process to determine the
9 fair value payment amount.

10 11 New Subparagraph; Unfair Insurance Trade Practices; Unfair Claim Settlement Practices by
11 Insurers. Amend RSA 417:4 XV(a) by inserting after subparagraph (14) the following new
12 subparagraph:

13 (15) Failing to make payment to the nonparticipating provider or facility within the
14 30-day period specified in RSA 420-J:8-e, IX.

15 12 Repeal. RSA 329:31-b, regarding a prohibition on balance billing and payment for reasonable
16 value of services, is repealed.

17 13 Effective Date. This act shall take effect January 1, 2025.

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2024-0049s

AMENDED ANALYSIS

This bill enacts, at the state level, the same requirements and prohibitions as exist under the federal No Surprises Act (NSA) regarding payments to, and billing by, out-of-network providers of emergency medical services and out-of-network providers of any health care service rendered at an in-network facility. As under the NSA, this bill requires health carriers to cover out-of-network emergency services and services provided at an in-network facility by out-of-network providers in the same manner as if the services were provided by an in-network provider or facility. It requires the health carrier to pay the out-of-network provider or facility a rate that is determined either through open negotiation between the parties or through a fair value independent review process made available by the insurance commissioner using the same fair value standards as are established in the NSA and the same independent dispute resolution (IDR) entities as are certified under the federal IDR process. Under this bill, upon failure of open negotiation between the parties, the health care provider or facility will have the option to utilize either the state or the federal IDR process. This bill also incorporates in state law the same prohibitions as are included in the NSA regarding balance billing by out-of-network providers for covered services provided at an in-network facility and for covered emergency services.

The bill is a request of the insurance department.